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ABSTRACT

One of the major reasons many children do not receive efficient, effective health care is that much of public spending for child health services has been funneled through categorical funding programs. The Child Health Initiative provided an opportunity to learn how different communities would approach improving child health services through "decategorization" of child health funds. This report describes the lessons learned from nine community programs and provides a profile of each program. The introduction discusses the structure of publicly supported health programs, the increasing numbers of children with multiple health care needs, and the Child Health Initiative. Section 2 summarizes lessons learned from implementation within an environment of cost-containment measures: (1) fragmentation of child health services is a real barrier to effective health care; (2) fragmentation of child health services can be reduced; (3) significant child health financing reforms are difficult to achieve and are best pursued in conjunction with service delivery innovations; (4) it takes time to demonstrate improvements in child health services; (5) the use of expert, specialized technical assistance can facilitate real innovations in established child health program; (6) a relatively small investment can result in a significant community initiative to improve child health; and (7) communities will eagerly embrace an effective family-centered care coordination program for children. Section 3 profiles the nine community programs, describing the services provided, the population served, and financing information. The report concludes with contact information for the projects and members of the advisory committee and program staff. (KB)

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Improving Child Health Services

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The Robert Wood Johnson Foundation

Elevating the health status of children is a top priority of The Robert Wood Johnson Foundation. Since its inception in 1972, the Foundation has awarded grants totaling more than $400 million for innovative programs designed to improve the health of America's infants, children and adolescents. Several of the Foundation's grant programs, such as those in school health and mental health services for youth, are making a major impact on the way in which services are delivered to children. The Foundation's Child Health Initiative, in operation from 1991 to 1997, is an example of such a program.

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Improving Child Health Services

Lessons Learned from Nine Community Efforts

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Foreword

SINCE THE 1950s America has made major improvements in the access to health care for poor children. The Medicaid program, a federal-state partnership, has provided access to the most critical health care services for children in families with the lowest incomes. In addition, school breakfast and lunch programs, nurse home visiting programs, school-based clinics, community health centers, migrant farmworker health programs, immunization programs and many others have fostered major improvements in the health of poor children. Despite the dramatic improvements in technology and services, however, there are many children who do not receive health care that is both efficient and effective. One of the major reasons for this deficiency is the fact that a significant percentage of public spending for child health services has been funneled through categorical funding programs. Categorical funding tends to be inflexible, making it difficult to connect the available dollars to the service needs of a child. This well-intentioned system has impeded the delivery of comprehensive, client-centered health care. Categorical funding has spawned multiple independent organizations, each set up to address a single health problem. Multiple providers treating separate problems in the same child is neither efficient nor effective.

Despite the dramatic improvements in technology and services, however, there are many children who do not receive health care that is both efficient and effective. One of the major reasons for this deficiency is the fact that a significant percentage of public spending for child health services has been funneled through categorical funding programs.

The Child Health Initiative was viewed as an opportunity to learn how different communities would approach improving child health services through "decategorization" of child health funds. This worthy endeavor was recognized from the beginning to be a high-risk venture due to the many pressures to maintain categorical integrity in each child health program.

The nine programs described in this publication met varying degrees of success in their decategorization efforts. The fact that these community efforts were able to achieve as much as they did in the face of a very difficult and changing health care market place is due to the dedication of those running the programs and the technical help of talented staff and consultants. The experiences of the Child Health Initiative are conveyed in this publication as lessons learned in order to maximize the benefit of our experience to other communities. A profile of each of the nine programs funded under the Child Health Initiative is also provided which summarizes the approaches taken by each participant community.

—Robert Haggerty, M.D., Chair,
Child Health Initiative National Advisory Committee

Introduction

DESPITE OUR advanced medical technology and a more than ample supply of well-trained medical care providers, many American children do not receive health care that is well-coordinated, efficient or effective. Fragmentation in the provision of child health services is a major part of this problem. Seeking to demonstrate the benefits of comprehensive, family-centered, well-coordinated child health care, The Robert Wood Johnson Foundation developed the Child Health Initiative. The Child Health Initiative was designed to test the feasibility of stimulating structural changes in how health services for children are financed and delivered. This publication profiles the issues, lessons learned and the nine community projects funded under The Robert Wood Johnson Foundation's Child Health Initiative.

Well-intentioned health care providers often feel handicapped in their ability to treat children effectively because they cannot integrate their services with those of other health and social service providers.

THE PROBLEM

Most public funding for child health services flows from distinct programs that are separately regulated by federal and/or state agencies. In many cases, the vital health services funded through this rigid categorical system have given rise to agencies and programs that provide only a single service or narrow set of closely related services. This system evolved from the tendency of Congress to act on specific health problems as opposed to broad health care needs. As such, communicable diseases, chronic diseases and preventive health services have been separately funded through numerous pieces of legislation. Today, entirely separate programs exist for preventive health services, maternal and child health services and family planning services. Such categorical funding provides Congress and states with the ability to target limited resources to specific health problems. It also affords policy makers with an opportunity to champion or to be identified with funds for a specific disease or service deemed to be a national or state priority.

The heightened visibility afforded each categorical health program in federal and state budgets has helped assure the survival of funding that otherwise might have been lost to public spending reductions. Advocates for a particular categorical program have been able to effectively organize a constituency bound by common interests or concerns. Public funding trends and legislative action can be more readily tracked in the current system. This precise targeting and legislative visibility, however, has contributed to the fragmentation of services for children and has created burdensome logistical problems for their parents.

The structure of publicly supported health programs is one of two major problems addressed by the Child Health Initiative. The second problem is that an increasing number of children have multiple health care needs. Low-income American children, particularly, have needs for primary medical care, mental health counseling, substance abuse counseling and preventive health services. In today's environment two or more agencies easily could be involved in addressing each of a child's specific problems while underlying problems go unattended. It is also quite possible that one care provider has no working knowledge of another's treatment plans and may be completely unaware of the other's services. This lack of coordination in the provision

of child health services is particularly troubling at a time when many studies are documenting the compounding effects of multiple health problems that impact children of low socio-economic status. Well-intentioned health care providers often feel handicapped in their ability to treat children effectively because they cannot integrate their services with those of other health and social service providers.

Multiple health care needs among children have been associated with the multiple risks that many families face today. These risks include, but are not limited to: neighborhood violence, inadequate nutrition, physical abuse, sexual abuse, substance abuse, homelessness and severe stress-related mental health problems. These factors are particularly pertinent for the more than 15 million American children (one in five) who live in families with incomes below the federally established poverty level. Numerous studies have linked poverty with poor health status and low levels of achievement.

Much of the press coverage and analyses of the current problems facing American children make the situation seem nearly hopeless. The alarming increase in child poverty and recent losses in health insurance coverage of children have some generally reserved social scientists using words like "crisis" to describe the current situation. Many of the federal programs initiated in the 1950s and 1960s, however, have helped make major improvements in the health status of America's children. Most notable among these programs are the Special Supplemental Food Program for Women, Infants and Children (WIC), the Maternal and Child Health Block Grant, Medicaid and the Community and Migrant Health Centers program. These and other federally sponsored programs, some of which are administered cooperatively with state governments, have helped make vast improvements in health care for children. It is important to note that major improvements in child health can be achieved through publicly supported efforts. The Child Health Initiative simply addresses one of the greatest remaining challenges: maximizing the effectiveness of our exceptional technical health service capabilities to meet the multiple health needs of today's children.

The prime objective of this initiative was to test the feasibility of improving the efficiency and effectiveness of child health services through the decategorization of child health funding streams.

THE CHILD HEALTH INITIATIVE

In response to the problems brought on by categorical funding of child health programs and the increase in the numbers of children with multiple health care needs, The Robert Wood Johnson Foundation created the Child Health Initiative: Removing Categorical Barriers to Care program. The prime objective of this initiative was to test the feasibility of improving the efficiency and effectiveness of child health services through the decategorization of child health funding streams. The decategorized grant funds would, therefore, allow the achievement of greater flexibility and coordination between those services required by children with multiple health care needs.

Although The Robert Wood Johnson Foundation was open to multiple approaches under this initiative, each demonstration site was required to address three major project components:

- **Ongoing monitoring and surveillance of the health needs of the communities' children.**
- **Individualized care coordination to assist the child, parents and providers of care in assuring that all required services were provided and coordinated.**
- **A decategorization mechanism that could achieve flexible financing of the various services required by children.**

The Child Health Initiative National Advisory Committee, composed of national leaders and innovators in the child health field, was assembled by The Robert Wood Johnson Foundation to provide guidance and direction during the start-up and implementation phases of the program. The Robert Wood Johnson Foundation staff responsible for the Child Health Initiative established the National Program Office, based initially at the University of Minnesota and subsequently at the University of Washington, to provide technical support and monitoring of the implementation of the grantee's projects. An evaluation team based at the University of California, San Francisco was engaged to provide a neutral assessment of the process used by each grantee to design and implement their project.

Communities with both the interest and capability to achieve the prime objective of the Child Health Initiative were identified. Selected communities were then invited to apply for grant funding. Between 1991 and 1993, 10 communities were funded under the Child Health Initiative to pursue improvements in child health services by reducing categorical barriers to care. Nine of the ten projects originally funded remained operational through 1996. Their approaches to the very ambitious task of decategorization were quite varied. While only a few of the projects made real progress toward the main goal of creating a discretionary funding pool by decategorizing federal, state or local grant funds, most of the projects were successful in attaining new resources through creative approaches to project financing.

Each of the Child Health Initiative projects raised public awareness of their community's most pressing child health needs through the development of county-wide child health status reports. They also developed care coordination or case management programs which effectively integrated the provision of health and social services to children with multiple health care needs. Although these items were not part of the primary objective of the Child Health Initiative, they proved to be the most successful endeavors.

Only the Monroe County Child Health Initiative in Rochester, New York, has come close to achieving true decategorization. Although several other projects successfully integrated different types of grants to fund a new service program, they did not remove categorical restrictions from any grant funds.

The federal government is starting to provide increased flexibility to state governments in shaping demonstration programs and traditional health service programs. State governments will likely become more accountable for the effectiveness of publicly supported health services for poor children as a result of these changes. In such a climate, public policy makers will be under great pressure to make *innovative* changes in publicly supported child health services. Pilot or demonstration programs like the Child Health Initiative are excellent vehicles for assessing various service delivery improvement strategies. This publication conveys some lessons learned that are pertinent to state and local efforts to improve health service delivery to children.

Lessons Learned from the Child Health Initiative

The Robert Wood Johnson Foundation's Child Health Initiative was implemented on the cusp of a period of rapid and dramatic change in the American health care system. For that reason, the nine projects funded through the Initiative soon faced challenges that had not been anticipated when the Initiative began. For example, most of the projects were designed to operate within the context of federal and state programs that, for three decades, had been the major sources of health care for poor children in America. Yet shortly after the projects began, a wave of health care cost-containment measures were initiated in states throughout the country. As part of this trend, many states moved families from the traditional Medicaid fee-for-service system into managed care plans. In the process, long-standing assumptions about the system of health care services for poor children were shaken and the Child Health Initiative projects, which had been based on those assumptions, were forced to adapt quickly to a new reality.

It is now apparent that the Child Health Initiative projects are not alone in needing to adapt to these trends. It is now certain that managed care and other reforms initiated during the past five years will have a lasting impact on health care services for poor children in our nation. Whether that impact proves beneficial is still an open question. The answer will depend on the willingness of policy makers to look honestly at both the strengths and weaknesses of their reforms and make changes when necessary to guarantee that these children are well served by the new systems that have been put in place.

In that context, the Child Health Initiative provides important lessons for state and local policy makers. For, in spite of the volatile conditions in which they worked, the nine projects managed to demonstrate the largely untapped potential of community-based strategies to improve services for children with complex health care problems. This publication provides a brief summary of seven significant lessons which have been gleaned from their experiences. These lessons learned were developed by National Program Office staff and draw on the observations and insights of grantee project staff, Evaluation Team, National Advisory Committee and Foundation staff. It is our hope that these lessons will help federal, state and local policy makers put the needs of children at the heart of health care policy and programs in this era of rapid change.

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Lessons

1

Fragmentation of child health services is a real barrier to effective health care.

2

Fragmentation of child health services can be reduced.

3

Significant child health financing reforms are difficult to achieve and are best pursued in conjunction with service delivery innovations.

4

It takes time to demonstrate significant improvements in child health services.

5

The use of expert, specialized technical assistance can facilitate real innovations in established child health programs.

6

A relatively small investment can result in a significant community initiative to improve child health.

7

Communities will eagerly embrace an effective family-centered care coordination program for children.

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1 *Fragmentation of child health services is a real barrier to effective health care.*

MOST OF the health services required by children with multiple health care needs are only accessible through complex public and private systems. These systems often rely on separate agencies to deliver a single, specific service. Service delivery agencies with such a specialized focus are not always effective in meeting the total needs of a child. Few communities have been able to weld these focused, specialized services into a comprehensive, coherent system in which all aspects of health care are well coordinated. The efficiency and effectiveness of the uncoordinated care provided in our resulting fragmented system remains a major challenge for almost all American communities.

In soliciting applications for the Child Health Initiative, representatives of The Robert Wood Johnson Foundation found a high degree of awareness of the problem of child health services fragmentation. There was a general consensus among community leaders that reducing such fragmentation was a priority. The existence of fragmentation was further validated by the staff of each Child Health Initiative project, which often encountered the issue in their daily work with children and families. In each community, children frequently were identified who were using the services of several health care agencies without any coordination between those services.

The Child Health Initiative grantees recognized the merits of specialized services but observed, first hand, the myopia that this specialization creates.

2 *Fragmentation of child health services can be reduced.*

THE TASK of fashioning comprehensive, family-centered, integrated services for children with multiple health care needs is daunting. The way in which services are organized and delivered is deeply entrenched in systems of provider training, public funding and service delivery protocol. Changes in the fundamental structure of systems of care generally were beyond the capacity of the Child Health Initiative grantees. Many grantees, however, were able to provide well-trained care coordinators with a broad perspective of the entire system and knowledge of how a parent could best access the services required by their child. In some cases this experience helped improve the coordination of services to clients served by multiple agencies. Some of the Child Health Initiative grantees worked with and through schools to provide care coordination services. Other grantees chose to work through community service centers or home visiting programs. Several Child Health Initiative grantees tried some combination of these two approaches.

It is evident from the testimonials of teachers, school principals and parents that improved access to care, more efficient utilization of care and overall coordination of care can be improved for at-risk children. The more efficient use of existing resources realized through these defragmentation initiatives appeared to have a cost-saving effect on publicly supported service delivery systems.

3 *Significant child health financing reforms are difficult to achieve and are best pursued in conjunction with service delivery innovations.*

ANY MAJOR CHANGE in the way in which child health services are financed requires government approval at both the state and federal levels. Any significant change in a federally administered program generally requires approval by a federal regional office and central office. Additional clearance may be required from the federal Office of Management and Budget when changes in standard federal program management protocols are required. State governments often require multiple approvals as well. Approval of demonstration projects that attempt to employ strategies such as decategorization on any scale must go through these approval processes. The state and federal waiver and/or approval process for pilot projects seeking to demonstrate innovative financing mechanisms are best received when accompanied by service delivery innovations.

In addition to the formal governmental approval processes, all of the other major stakeholders in child health programs need to support the proposed financing reforms. Key service delivery and advocacy organizations need to be convinced that any proposed financing reforms will not have negative side-effects. The challenging political and turf issues involved in financing reforms are almost insurmountable without persistent cooperation of the major stakeholders.

Those Child Health Initiative projects that had the greatest success in getting state and federal approval of significant changes in child health financing tended to have the most well-developed care coordination or service delivery improvement strategies. Strong service delivery improvement plans tended to bolster the credibility of some Child Health Initiative grantees seeking approval of financing reform demonstration projects. Care coordination projects that relied on strong home visitation components were the most successful in the Child Health Initiative experience.

4 *It takes time to demonstrate significant improvements in child health services.*

REAL CHANGES in the organization and delivery of child health services generally require sustained multi-year efforts. Even at the demonstration program level, the complexities and rigidity of our existing health service programs make any meaningful change very difficult. The Child Health Initiative experience confirms the observations of other child and family service initiatives in validating the importance of allowing sufficient time to implement truly innovative programs.

Fashioning innovative service delivery programs through decategorization of categorical grant funds involves rather complicated approval processes at state and federal levels. Gaining approval to use very restricted grant funds for broader purposes proved to be even more time consuming than anticipated. The normally lengthy process of getting waivers and approvals from state governments was further complicated by turnover in key state administrative positions and in governor's offices.

Beyond the time requirements for planning and developing innovative child health services lies the refinement of operations. Implementation of the perfect operating plan on the initial try is a rare occurrence. Program modification based on continuous feedback from front-line staff and clients is usually required to fine tune a program for optimal performance. The time required to realize useful results adds an additional dimension to the overall time requirements.

The Child Health Initiative grants initially were made for three-year periods. The operating periods of the nine Child Health Initiative grantees were extended from one to two years. Some of the most significant accomplishments were made during these extension periods. It is likely that other major accomplishments will be made years after Foundation support has ended.

5

The use of expert, specialized technical assistance can facilitate real innovations in established child health programs.

THE ESTABLISHMENT of innovative child health programs can be greatly facilitated with the use of specialized technical assistance. Major modifications in the way child health services are organized and delivered involve complicated processes with which very few health and human service professionals are experienced. The efficient and expeditious packaging of state and/or federal waivers and the effective coordination of autonomous health services demand high-quality, specialized expertise. Professional consultants with successful experience in one of more of these processes can be a valuable asset in handling the technical aspects of these endeavors.

Some of the most significant accomplishments in the Child Health Initiative experience were the direct result of expert technical assistance provided by experienced consultants. Several Child Health Initiative grantees were able to leverage previously unrealized Medicaid revenues for support of their projects with the assistance of specialized financing consultants. Consultants also provided critical guidance to some of those Child Health Initiatives where formal working relationships were required between several separate service delivery agencies. Several Child Health Initiative grantees found that having a consultant serve as a third party in negotiations between state and local agencies improved communications and facilitated positive action.

Matching of specialty consultants to the technical assistance task(s) and to the recipient(s) of the technical assistance is of major importance. The best outcomes of technical assistance services came from situations where consultants with exceptional capabilities were employed, and from situations where consultants were highly compatible with Child Health Initiative project staff.

Although expert consultants are no substitute for capable staff, proper use of consultant services can build capacity in program staff to further a particular initiative and any successor initiatives.

Pathways
TO A
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Something
is Happening
to Our Children
SCOTT COUNTY CHILDREN'S HEALTH
WELL-BEING INDICATORS
Scott County
A Profile of
Cumberland County's
Children
KIDSTAT
Children's Health
A Status Report
Newcomer Children
in San Francisco
Their Health and Well Being
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6 *A relatively small investment can result in a significant community initiative to improve child health.*

PROGRESSIVE change in the way child health services are organized and delivered can be initiated without the infusion of massive amounts of new funding. Some of the more significant barriers to successful use of child health services are structural in nature. Improvements in structure can be accomplished with relatively modest investments in staffing and technical assistance.

The Child Health Initiative implementation grants to the nine grantees averaged $500,000 for a projected three-year project period. Most of the Child Health Initiative grantees required more time than anticipated and actually used these funds over a four- to five-year period. Foundation funds made available through the Child Health Initiative were used predominantly for administrative staffing, care coordination services staffing and technical assistance. This amount of funding only allowed for very small neighborhood-based demonstration projects. However, the experience obtained in the planning and development of these small projects is easily transferable to larger scale initiatives.

Several Child Health Initiative grantees were able to get annual child health status reports institutionalized within their communities. Other grantees were able to develop replicable models of school- and community-based care coordination programs, which continue to operate without Foundation support.

7 *Communities will eagerly embrace an effective family-centered care coordination program for children.*

THERE IS certainly no shortage of new initiatives for children. Local, state and federal governments; private foundations; schools and other agencies have spawned a vast array of special initiatives for children in recent years. Many of the children's initiatives dissipate when the sponsoring agency or funding sources come to the end of a specified period of support. The Child Health Initiative operated at a time characterized by increasing pressures on dwindling resources for child health services. Despite the financial constraints of the times, several Child Health Initiative projects secured funding from local sources for continuation of their care coordination operations. This local support most frequently came from city government, county government, school systems and state government.

Beyond local financial support for continuing care coordination services, several Child Health Initiative projects enjoyed local support in the form of donated services and goods for young families. Those projects that were the most successful at establishing effective public information, public relations and community governance elements were similarly successful in attracting volunteers (professional and non-professional), obtaining donations of children's clothing, household goods, and securing collaborations with professional health and social service delivery agencies. The child health status reports were effectively used as a central element of community information strategies. The most successful programs augmented these reports with newsletters, public announcements and solicited press coverage.

The Child Health Initiative projects with the most successful care coordination programs used an enabling and empowering approach to support young families with children. The focus on enhancing the abilities of parents to manage the acquisition of health and social services for their children was popular with both liberal and conservative community members. Parents responded quite positively to programs that provided social advice and direction instead of assuming management control of their child's health and social service acquisition.

The combination of effective communication strategies regarding the needs of children and the enabling/empowering approach to care coordination proved to be key in the most successful care coordination programs devised by the Child Health Initiative grantees.

Project Profiles

This section contains brief descriptions of the nine Child Health Initiative projects. In addition to providing a general overview of each project, the descriptions identify the populations served, explain in detail how each project was structured, and offer insights into how each project was financed. Although this document identifies the projects by the name of the city in which they were located, each was funded as a county project with each grantee having the option to focus on sub-county priority areas.

The scale of the nine Child Health Initiative projects varied widely, with some projects serving a limited number of clients and others serving a much larger population. The Portland, Maine; Rochester, New York; and Texarkana, Arkansas, projects initially served less than 65 clients. The Flint, Michigan and Salem, Oregon, projects were each focused on two elementary schools in their target areas and served as a resource for students and their families. The San Francisco, California, project maintained an active caseload of 10 to 20 families. The Seattle, Washington and Davenport, Iowa, projects were each part of larger initiatives that served several schools in their target areas. The Minneapolis, Minnesota, project was a component of a larger system that served a significant number of clients.

Six of the Child Health Initiative projects were created with grant funds provided by The Robert Wood Johnson Foundation. One exception was the Minneapolis, Minnesota, project which was established prior to the start of funding from The Robert Wood Johnson Foundation. The other exceptions were the Seattle, Washington and Davenport, Iowa, projects which evolved from existing community programs.

Several of the projects, most notably Rochester, New York and Texarkana, Arkansas, were still in the development phase at the end of their grant funding periods. Six of the nine projects have been adopted as ongoing activities within their communities. Each project served as a significant learning experience within its respective community and provided valuable lessons in reforming children's health services at the local level. The general success of the individual Child Health Initiative projects stands as a testimony to the tremendous energy, commitment and dedication of the key staff of each project who took on a most difficult challenge. The tireless efforts of these innovative individuals was the key factor in the success of the Child Health Initiative projects.

Scott County Decategorization Program
Davenport, Iowa

A school-based comprehensive health services and family resource program

Sometimes one small cry for help reveals a much bigger problem. A school referred a second-grade girl to Scott County Decategorization Program's Child Health Initiative (DECAT). When a Family Service Coordinator made a home visit, the girl's mother voiced two major concerns: a three-year-old son who was "out of control" and the recent arrest of the girl's father on multiple drug charges.

Because DECAT provides links to many other programs, this same Family Service Coordinator could arrange for services the family needed: parenting skills classes, substance abuse education, marital counseling and child care. The coordinator also linked the family to agencies offering financial, legal and medical assistance.

Who is served? DECAT targets children and families who are eligible for Medicaid, and low-income families without health insurance coverage. The program's Family Service Centers provide care coordination for any child or family having assistance needs. Health promotion and disease prevention programs are open to all Scott County children and families.

How does the project work? The four school districts participating in DECAT offer services customized to meet the needs of their communities. School district programs range from health promotion and disease prevention activities to comprehensive Family Resource Centers. The Family Resource Centers or School Health Centers are available in six elementary and two intermediate schools. Less comprehensive services are offered in seven additional schools. Children attending private schools have access to these centers, too. Some programs, such as the Dental Sealant Program, are available across all school districts.

The DECAT program provides care coordination through school-based family resource coordinators, juvenile court liaison staff, and the in-home visitors of the Medicaid preventive services program (EPSDT). The program also makes referrals and facilitates access to other services for students and families. These services include medical and dental, chemical/alcohol abuse prevention, domestic violence counseling, mental health, immunizations, lead screening, human services, juvenile court liaison, and care coordination.

The schools, DECAT and community agencies collaborate to offer spin-off programs at the school sites. One such program distributes winter clothing; others offer parenting, tutoring, mentoring and skill development programs. One school offers an active, neighborhood juvenile justice crime prevention program. This program links community agencies, law enforcement and schools to build strengths among youth, families and the neighborhood.

How is the project financed? DECAT integrates funding from federal and state sources, federal education funds, tax-based school funds, school-related categorical funding, Department of Health and Human Services funds, local grants, and donations to provide school-based services. DECAT also uses Medicaid Administrative Claiming reimbursements to purchase health-related services at the participating agency level and for a flexible funding pool.

Grant Starting Date: June 1991

Grantee Agency: The Child Abuse Council

"I can't begin to tell you how significant the impact of having the Family Service Center at J.B. Young [Intermediate School] has been. The ability to provide these services to our students and their families has made a tremendous difference in the success of our students and in the morale of the staff. Having once experienced these services in a school setting, I cannot imagine doing without them."

Rex Hutchison, Principal
J.B. Young Intermediate School

"The project acted as a catalyst to develop a true community health vision for children."

Lawrence E. Barker
Scott County Health Department

"Developing and implementing the Smart Start project provided invaluable insights into how diverse community partners can collaborate on behalf of children and families. It also taught us the difficulties and complexities in exacting system changes."

Dorothy Reynolds
President, Community Foundation of Greater Flint

"The Dailey Smart Start Center has made a real impact on some of our children and families, especially in terms of school attendance, prenatal participation and neighborhood support."

Ira Rutherford
Superintendent, Beecher Community Schools

Smart Start
Flint, Michigan

A school-linked program of prevention-oriented services

Few towns in America have had a tougher time in recent years than Flint, Michigan, where profound changes in the auto industry left a once-thriving community with staggering unemployment. In this environment, the Smart Start program is building on the hidden strengths of families and neighborhoods to improve the health of Flint's children.

While most health and social services programs begin with financial screening procedures that force a family to prove how badly it needs help, Smart Start avoids procedures that label clients as dysfunctional or disadvantaged. Instead, Smart Start services begin with a "strengths assessment," emphasizing those characteristics the family already possesses that could help parents succeed in making a better life for their children.

Building on that foundation, Smart Start works with the families through the elementary schools where their children attend classes, offering a wide array of support services for the whole family.

Who is served? The project serves children and their families living near two inner-city elementary schools in adjoining districts. At one school, Smart Start serves children from infants through sixth grade; at the other, infants through fourth grade.

How does the project work? Smart Start has set up a family resource center at each of the two schools. Each has a separate outside entrance so parents using the center can come and go freely. These centers offer comprehensive, preventive health and family support services in a warm, nonthreatening and culturally appropriate setting. Activities include medical screening; counseling; information about and referrals to Medicaid, food banks, clothing programs and shelters; and classes for parents, such as family finance, aerobics and cooking. The centers also offer easy-to-read materials about common health and parental concerns. Staff includes a site manager, family outreach worker, volunteer coordinator, Americorps workers and volunteers from the community.

Smart Start also has influenced several initiatives in the wider community. These new efforts have adopted Smart Start's collaborative process and model of school/neighborhood-based strategies. Several participants in Smart Start's development now serve on Genesee County's new collaborative body that is working to integrate services for children and families.

How is the project financed? In its first three years, Smart Start received funding from the county health department, school districts, the local substance abuse agency, and community and foundation sources. Since 1994 the project has been funded principally by Mott Children's Health Center, the two local school districts and the Community Foundation. Smart Start also receives grants from the City of Flint and a local HMO, and many donated services. The project is working to develop financial relationships with managed care providers and other community funders.

Grant Starting Date: September 1991

Grantee Agency: Community Foundation of Greater Flint

Delegate Agency: Mott Children's Health Center

Way To Grow
Minneapolis, Minnesota

A community-based program promoting school readiness

Tynisha LaDuke's entry into kindergarten didn't seem like the kind of event that would get an article in the newspaper. A healthy, eager-to-learn five-year-old, she was exactly the kind of student every teacher hopes for. Yet Tynisha's success in preparing to enter school was worthy of attention because her family had to overcome some tough circumstances to get her there.

Tynisha's mother gives much of the credit for her success to Minneapolis' Way To Grow Program, a neighborhood-based project to improve the prospects of the city's young children. As Tynisha's mother put it, "I grew up seeing drinking and violence in my family and I wanted a different life for my child." Working through community centers in eight locations, the Way To Grow programs offer families help in securing health care, housing and employment as well as many other services so their children will be ready to learn when they get to school.

Who is served? Way To Grow (WTG) serves pregnant women and families with children age six and under. WTG emphasizes universal access to its community centers. However, a significant proportion of those served are Medicaid-eligible families with multiple problems in the areas of health care, housing, employment and family stability. WTG service centers are located in eight of the city's 11 planning districts.

How does the project work? Each Way To Grow service center reflects the interests and priorities of its neighborhood. The centers offer care coordination and a variety of special activities, such as parenting skills classes, family safety fairs and a community child care program. A collaborative council of community residents, agencies, and health and corporate sponsors guides each site.

Paraprofessional home visitors coordinate care for families participating in WTG. Home visitors come from the same neighborhoods as the client families. The home visitors link families with services to meet needs ranging from prenatal care to financial support to jobs. Home visitors consult with an interagency resource team: a public health nurse, a parent educator and a children's mental health specialist.

How is the project financed? Way To Grow is funded by pooled contributions from public schools; city, county and state health and education departments; health plans, hospitals and clinics; the United Way; local businesses and corporate foundations. The community selects nonprofit neighborhood organizations to receive funding from this pool to develop and operate WTG centers. WTG receives Medicaid and Child Welfare administrative reimbursements and is exploring ways to qualify for reimbursements from Medicaid managed care providers.

Grant Starting Date: December 1991

Grantee Agency: Minneapolis Youth Coordinating Board (City of Minneapolis, Minneapolis Public Schools, Hennepin County, Minneapolis Park and Recreation Department, Hennepin County District Court – Juvenile Division)

"School readiness is more than just knowing one's alphabet – it is about a child having the emotional, social and physical skills to function in the classroom. This does not happen with any one program but with a caring team of empowered parents, community members and professionals working together to ensure children reach their full potential."

Sharon Sayles Belton
Mayor of Minneapolis and Chair,
Minneapolis Way to Grow

"Way to Grow is more a process than a program. Way to Grow serves families by first meeting with families and community members to learn what their needs are and what strategies they would like to employ to meet those needs."

Way to Grow Newsletter

"Case Management for Youth's outreach has pulled kids into the formal service system who otherwise would have drifted from shelter to shelter or wandered the streets homeless until they ended up in the State's corrections system or a residential in-patient facility."

Tanya Busch
Executive Director,
Case Management for Youth

"Case Management for Youth enables families to care for their children at home – children who in the past would have been placed in a residential treatment facility."

Fran Finnegan
Deputy Director
Bureau of Medical Services,
State of Maine

Case Management for Youth Portland, Maine

A community-based service network for high-risk teens

Like many American cities, Portland, Maine, had become a magnet for troubled youth, and had no good answer for how to deal with them. Typically, adolescents with severe behavioral problems were sent to psychiatric hospitals or placed in foster care. This did little to address the many root problems that had gotten the young people into trouble–mental illness, behavioral disturbances, drugs and alcohol, or homelessness.

The Case Management for Youth project was designed to address these problems by providing alternatives for those youth with pressing health and social service needs. The program aims to simplify access to services and, ultimately, to connect the youth with local resources to ensure a stable living arrangement and the ability to function in the community.

Who is served? Case Management for Youth (CMY) works with adolescents, ages 11 to 17, who have mental health problems. These are high-risk youth who otherwise would "fall between the cracks" of the health and social service system. Their mental health needs limit their functioning and quality of life at home, at school and in the community.

How does the project work? CMY operates on a decentralized case management system to coordinate services across many agencies and disciplines. Community sources, including schools, social service agencies, health care providers and families, refer adolescents to CMY. A six-member, interdisciplinary team screens the referrals. Eligible adolescents are referred to a case manager in participating local agencies.

The case manager meets with the family and youth, then convenes an interdisciplinary, core service team. This team helps the adolescent and family to set individual goals and create a service plan. The case manager helps the adolescent and family develop short- and long-term goals, identifies resources, and coordinates and advocates for services.

Families and teens participate in all aspects of CMY, from developing the program to serving on advisory committees. The result is a program that reflects the needs of those it serves, where parents and teens are invested in the program's success–and their own.

How is the project financed? Medicaid reimburses CMY through a new category for targeted case management services, which the project negotiated. United Way of Greater Portland contributes in-kind services. Participating agencies and the state's mental health department provided seed money. CMY is negotiating with the state Medicaid agency to develop a capitated rate for mental health services.

Grant Starting Date: February 1993

Grantee Agency: United Way of Greater Portland

Delegate Agency: Case Management for Youth, Inc.

Monroe County Child Health Initiative
Rochester, New York

A home visitation community-based program

When the Rochester, New York, community focused on the health of low-income children, it devised a strategy that featured a local time-honored tradition: home visits. Starting in the first year of a child's life, the Monroe County Child Health Initiative provides weekly or biweekly visits by trained paraprofessionals who coordinate the health care of the mother and child, provide parenting education, assure that preventive measures are being followed and arrange for services if problems arise. These paraprofessional home visitors function as part of a recently improved early intervention home visiting service program operated by the Monroe County Department of Health.

This strategy has proved so successful that it is being incorporated as a permanent part of the care at Rochester General Hospital and is beginning to receive reimbursements from managed care plans.

Who is served? The initiative serves high-risk mothers, infants and children up to age two who live in the northeast quadrant of Rochester, one of the poorest areas of the city, and who are patients of Rochester General Hospital's outpatient centers. The focus is on families with children who are at high-risk of developmental difficulties because of social and economic factors but who do not have a documented disability or chronic condition.

How does the project work? The initiative invites families to participate during pregnancy. Paraprofessional home visitors drawn from the local community serve as peer counselors and care coordinators. A community health nurse supervises the home visitors. The home visitors also stay in touch with the Rochester General Hospital pediatric care teams who provide health care for the families. Referrals to local Family Resource Centers are planned after the children served reach the age of two.

How is the project financed? The initiative has received approval from the State of New York for consolidation of eight federal and state maternal and child health grants. Final federal approval is anticipated in the very near future. The more flexible funds received through the consolidated grant would be used in conjunction with other federal block granted funds and state funds for services to young, at-risk children. As a result of negotiations with the area's major Medicaid managed care provider, the initiative has an agreement to provide limited home visiting and care coordination services to enrolled clients. The project also received Medicaid administrative reimbursements and United Way funding.

Grant Starting Date: July 1993

Grantee Agency: Monroe County Department of Health, in partnership with the Department of Pediatrics, Rochester General Hospital/University of Rochester

"The Child Health Initiative enables us to create the Child and Family Health grant from eight separate categorical programs. This will substantially improve the way maternal and child health services are delivered to families, and streamline Health Department administrative procedures. The end result will be better both for families and for the county."

Andrew S. Doniger, MD, MPH
Director,
Monroe County
Health Department

"Families, especially those who are isolated or non-English speaking, enjoy having someone come into their home on a regular basis. Families feel more in control in their own homes, where the worker is a guest."

Sally Farrell Partner
Operational Coordinator
Monroe County Child Health
Initiative

"We offer families tangible services. When they find they can count on us, they come back".

Eleanor Miller
Project Director,
Marion County Child Health Initiative

"When a child goes without immunizations or a doctor's care, we all suffer. It's up to each of us to make sure all children have access to high quality health care."

Jim Randall
Salem Hospital

The Child Health Initiative
Marion County (Salem), Oregon

A school-linked care coordination program

Early in its development, the Child Health Initiative in Salem, Oregon, learned an important lesson: one effective way to reach low-income families with preventive health services is to offer appealing events. Through bicycle rodeos and community dinners, mobile dental programs and other events, the initiative has mobilized the community to tackle a wide range of children's health problems.

Who is served? The initiative provides care coordination of health and social services to elementary school students and their younger and unborn siblings in families with incomes under 180 percent of the poverty level who live near one of two schools. The initiative also offers preventive dental services to pre-kindergarten children and emergency dental services to children and adults throughout Marion County.

How does the project work? Care coordinators at the two schools work with children and parents who need special attention. Care coordinators make home visits or meet with families at the Child Health Initiative offices or other locations. The family becomes part of a team that includes the care coordinator and a school staff person. The family helps determine what kind of help family members need and participates in developing a care plan. The care coordinator then helps the family identify and gain access to providers and an array of donated services to accomplish the plan's goals. The care coordinator contacts the family at least once a month and adjusts the care plan as needed. Care coordinators also stay in touch with families who have no current needs. Families may enter or leave the program at any time.

Just as the care coordination services build relationships with families, the initiative's Annual Health and Safety Fairs build relationships among families in five low-income neighborhoods and members of the wider community. The fairs are popular community events. Educational and fun, the fairs have attracted donated prizes and food from local businesses and direct health services from government and private providers.

Several spin-off projects inspired by the initiative now provide a variety of goods and services to those in need. These include children's bicycle helmets, home smoke detectors, blankets and clothing, and emergency dental services. These projects currently serve ten schools.

How is the project financed? The initiative's Child Health Fund receives funding from the initiative's partners (families, community and religious organizations, local and state government, schools, and private health care providers). These contributions include categorical and in-kind support. In addition, the initiative receives Medicaid administrative reimbursements and has attracted contributions and in-kind donations from local sources that allow for some discretionary funds.

Grant Starting Date: June 1993

Grantee Agency: Marion County Health Department

Child Health Initiative for Immigrant/Refugee Newcomers
San Francisco, California

A school-linked program for recent immigrant children

One in five children living in San Francisco was born outside the United States. Although many of their families were admitted into the country legally, they were met with few resources when they set foot in America. They know little about the American health care system, and the system knows very little about them. This puts them at a severe disadvantage in obtaining health care.

The Child Health Initiative for Immigrant/Refugee Newcomers reasoned that school registration provided a golden opportunity to begin bridging this gap. With the collaboration of the school district and the health department, the initiative placed bilingual, bicultural field workers in the registration centers to offer health screening and community resources as part of the registration process. This strategy achieved multiple objectives: It found children with immediate health needs, linked families with primary care and documented the health needs of the population.

Who is served? This initiative serves low-income, foreign-born children of elementary school age who have lived in the United States for two years or less and who have unresolved health or medical problems and/or are having difficulty in obtaining the health care services they need.

How does the project work? The initiative's bilingual and bicultural health workers make initial contact with families when they enroll their elementary-age children at the school district's central registration office. Locating at the registration center has enabled the initiative to reach immigrants within two or three months of their arrival. A public health nurse/health worker team provides an overall health screening, with an emphasis on immunizations and preventive care. They also make referrals for follow-up health care. The initiative developed tools for health screening, including an immunization record and health history, a nutrition screening questionnaire, a family service plan and referral forms. The initiative also created a training program with bilingual materials for health workers.

Children identified as high-risk receive case management through the initiative. This case management includes home visits by a public health nurse or health worker, screenings for health and social service needs, and referrals to connect families with the needed services.

How is the project financed? The initiative received funding from a state Medicaid grant (through the preventive health services program) and a local foundation grant.

Grant Starting Date: June 1992

Grantee Agency: City/County of San Francisco Department of Public Health

"Our greatest achievement in the area of service integration was assisting newly arrived immigrants in establishing their preventive health care and transitioning them into a new psycho-social environment."

Rosemary Lee
Coordinator,
CHIRN Program

"...We have learned that despite many difficulties immigrants and refugees experience in leaving their own country and settling in our community, newcomer children and youth arrive here in relatively good health and that, although they bring with them certain unique health problems, they can be corrected relatively quickly if timely interventions are provided."

Newcomer Children in San Francisco: Their Health and Well-Being—A Report by the Child Health Initiative for Immigrant & Refugee Newcomers, 1995

"Communities everywhere are looking for ways to build their capacity to respond to the needs of children and families, rather than build systems that are based simply on targeting problems."

Healthy Children, Youth and Families in King County: Data Summary and Guide to Community Planning, June 1995

"Flexible funds enabled school teams to fashion services and goods packaged to meet individual needs."

Cathy Gaylord
Coordinator,
Seattle/King County Child Health Initiative

Seattle Child Health Initiative
Seattle, Washington

A school-based program using an interagency, multi-disciplinary team approach

What can a school do when a child isn't getting needed medical treatments? Thanks to the Seattle Child Health Initiative, elementary schools in two areas are not only identifying problems such as this, but can take action to help.

For example, a nine-year-old girl who had a serious leg injury needed evaluation and fitting for a brace, but she kept missing appointments. Instead of just recommending to the parents that the child see a doctor, the initiative's Expanded School Intervention Team (Expanded SIT) met with the mother. They found that she faced two major barriers to getting her daughter to the hospital: language and transportation. The team arranged for a cab driver not only to transport the family to the hospital, but also to walk them to the appropriate clinic where they could connect with an interpreter.

Who is served? The initiative serves children in six elementary schools in southeast and central Seattle who have health or social service needs that are not being met.

How does the project work? Each school has an Expanded SIT composed of representatives from the school staff, and from public health, mental health, child welfare, public assistance, and other health and social service agencies. The Expanded SIT meets regularly at the school to assist with service planning for individual children, and includes parents as partners in this planning. A family support worker at each school coordinates the services in the family's plan.

Because of the initiative's flexible funding, the Expanded SIT and support workers can purchase goods and services not available through other programs. These range from mental health services to alarm clocks (which help children get to school on time). The initiative encourages the involvement of families in schools, and assists families who have limited English-speaking ability to participate in their children's school activities.

How is the project financed? The initiative pools funds decategorized by the legislature for the state's Readiness-To-Learn project, together with Medicaid administrative matching funds generated by work of the initiative's staff. City of Seattle discretionary funds also support the project.

Grant Starting Date: September 1991

Grantee Agency: Seattle-King County Department of Public Health

Our Children First Coalition
Texarkana, Arkansas

A community-based partnership of organizations in the child health field

One of the biggest barriers that keeps low-income families from getting the health services they need for their children is the sheer number of agencies they have to visit. Each agency is in a different location and has its own requirements and staff. In Texarkana, Arkansas, however, underserved residents are now able to receive comprehensive care by working with one Care Coordinator.

Each of 36 local agencies and groups in the Texarkana's Our Children First Coalition has sent staff members to a special training program to learn how to provide comprehensive services drawing on resources from all the agencies. Each of these "super" case managers is now cross-training other staff members in the participating agencies.

Who is served? The project serves all children requiring assistance from multiple agencies. Of particular concern are teens who are pregnant or who have young children, children diagnosed with serious emotional disturbance, and children who are at-risk or are in out-of-home placement.

How does the project work? This is a community-based coalition involving 36 local agencies and organizations–virtually every organization in the county that serves children in some capacity. The coalition has organized an extensive partnership and has planned its care coordination model. Care Coordinators from participating agencies are now being trained. Agency Care Coordinators will cross-train and oversee the case managers who work at local participating agencies. The Care Coordinators also will assure that the participating agencies work together effectively to provide services, referrals and follow-up for child health care.

How is the project financed? The coalition has been recommended to receive flexible funding from the Governor's Partnership Council for Children and Families, and has been pursuing enhanced Medicaid funding.

Grant Starting Date: October 1993

Grantee Agency: Arkansas Department of Health

Delegate Agency: Our Children First Coalition, Inc.

"The Miller County Child Health Initiative has had a dramatic impact on this community. For the first time in decades, we have almost a hundred agencies and service providers working together to achieve a common goal: the improvement of service delivery to children and families in our community."

Gerald A. Bedwell
President, Temple Memorial Rehabilitation Center

"Our Children First Coalition is ahead of its time in planning to provide services for Miller County children in need. It is a cooperative effort involving all agencies providing services in Miller County. I have never before seen such enthusiasm or such a willingness to work together."

Frances Holcombe
Director of Programs, Opportunities, Inc.

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